CONFIDENTIAL NEW PATIENT INFORMATION FORM

203 Elden Street Suite #301
Herndon, VA 20170
PHONE: (703)464-5597 FAX: (703)955-7838

Patient Details

Last Name: _____ First Name:_____ Middle:_____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Birth Date: ___/___/___ SSN: _____/_____/_____

Address:

City: **State:** **Zip Code:**

Cell Phone: **Home Phone:**

Email Address:

Employer Name:

Type of Work Performed:

Name of Spouse (parent, if you are a minor): **Phone:**

Primary Care Physician: **Phone:**

HOW DID YOU HEAR ABOUT US?

Visit Details

Chief Complaint:

Date Problem Started: **Auto Accident Related: :** ☐ Yes ☐ No **Work Related:** ☐ Yes ☐ No

Do you have a pacemaker? Yes ❑ No ❑

Other Secondary Problems or other Heath Problems? ☐ Yes ☐ No **Explain:**

Do you suspect that you may be pregnant? ☐ Yes ☐ No

Are you currently taking any over the counter medications? ☐ Yes ☐ No **Explain:**

Are you currently taking medications for the following: Anti-inflammatory ❑ Muscle Relaxants ❑ Birth Control ❑

Blood Thinners ❑ High Blood Pressure ❑ Pain Relievers ❑

Other ❑ Explain:

Have you ever been diagnosed with: High Blood Pressure ❑ Heart Attack ❑ Emphysema ❑ Seizures/Convulsions ❑

Thyroid Disease ❑ HIV ❑ TB ❑ Circulation Problems ❑ Cancer ❑ (If yes, please describe type of cancer):

Previous Chiropractic Care ☐ Yes ☐ No **Doctor:**

Please note: payment or insurance co-payment is expected at time of visit.

I understand that my care in this office may involve the making of judgments that are based upon the facts known by the doctor. Therefore, the above information is true and complete to the best of my knowledge. I also understand that the practice of any healing art is not an exact science and that no guarantee of results will be made by the doctor nor relied upon me. I further understand that the doctor's professional expertise lies in detecting and correcting structural and mechanical aberrations of the spine. I agree that he will not be held responsible for the diagnosis or treatment of any medical condition indicated above.

Patient Signature **Date**

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CHIROPRACTIC AUTHORIZATION RELEASE & EXPLANATION

CONSENT FOR CHIROPRACTIC TREATMENT

[ ] I hereby request and authorize Dr. Devinder P. Singh, D.C. at Spine and Laser Center to perform diagnostic tests and render chiropractic adjustments and other treatment. This authorization also extends to all other doctors and office staff members and is intended to include radiographic examination at the doctor's discretion.

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

[ ] I Authorize Payment of Any Medical Benefits from _____ to be Paid Directly to This Chiropractic Clinic for Any Service Rendered to Me.

AUTHORIZATION AND ASSIGNMENT

[ ] In consideration of your undertaking to care for me, I agree to the following:

1. You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred.
2. I authorize the direct payment to you of any sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services.
3. In the event any insurance company obligated by contractual agreement to make payments to me or to you for the charges made for your services refuses to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is believed to be correctly set forth under pertinent data) and authorize you to prosecute said action either in my name as you see fit and further authorize you to have been made to collect sums due for the insurance company, or companies, contractually obligated, you will refrain from attempts and efforts to collect the amounts owed directly from me. I understand that whatever amounts you do not collect from insurance companies' proceeds, whether it be all or part of what is due, I personally owe you.
4. I hereby waive the statue of limitations on collection regarding my case and care.
5. I further agree that this Authorization and Assignment is irrevocable until all monies owed are paid in full.

MEDICAL RECORDS RELEASE AUTHORIZATION

I, _____, do hereby authorize the Spine and Laser Center/Dr. Devinder Singh, to obtain any and all medical records deemed necessary for my treatment at the above referenced facilities. This authorization includes but is not limited to: X-rays, MRI's, any diagnostic imaging results reports, medical history forms, physician reports, urgent care medical records, laboratory results, and any other medical records requested by the Spine and Laser Center/Dr. Devinder Singh. Excluded in this authorization are any psychological or psychiatric records and any medical records that pertain to the mental health of my person.

SIGNATURE _____ DATE _____

SPINE AND LASER CENTER

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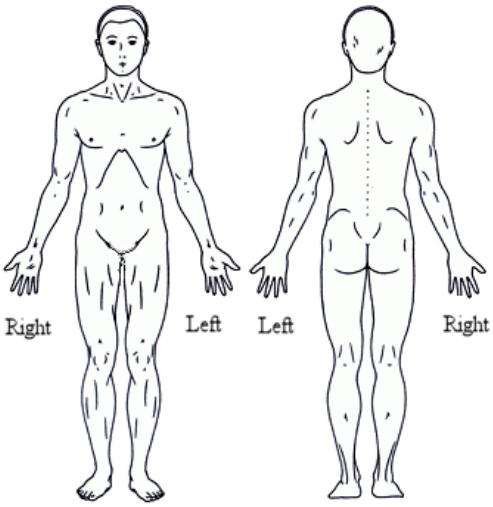
Have you had similar problems/injuries/complaints before? Yes ❑ No ❑

If yes, explain:_____



Please circle degree of pain, 0 none, 10 severe pain.

0 1 2 3 4 5 6 7 8 9 10

Using the symbols below, mark on the pictures where you feel pain.

Numbness	= = =
Dull Ache	OOO
Burning	XXX
Sharp/Stabbing	/ / /
Pins, Needles	+ + +
Other _____	^ ^ ^

Is your pain: Constant❑ Intermittent❑
If your pain is intermittent, how often and how long does it last?_____
Does the pain radiate to your arms or legs?_____
What activities aggravate your condition/pain?_____
What activities lessen your condition/pain?_____
Is this condition worse during certain times of the day? Yes❑ No❑ If Yes, explain_____
Is this condition interfering with Work❑ Sleep❑ Daily Routine❑ Other❑ _____
Is this condition progressively getting worse? Yes❑ No❑
History of car accidents? Yes❑ No❑ If Yes, explain:_____
Major Surgeries/Operations? Yes❑ No❑ Explain:_____
Previous Fractures or Broken Bones? Yes❑ No❑ _____
Do you have frequent Headaches? Yes❑ No❑ If yes, how often?_____
Do you have any foot/ankle/knee pain?_____

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health.
I agree to allow this office to examine me for further evaluation.

Print Name_____

Patient Signature_____**Date**_____